

1. Last Name

First Name

MI

NC Department of Health and Human Services  
Public Health Nursing and Professional Development

## CHILD HEALTH FLOW SHEET

2. Patient Number									--	H	
3. Date of Birth									Month	Day	Year
4. Race	<input type="checkbox"/> 1. White <input type="checkbox"/> 2. Black/African American <input type="checkbox"/> 3. American Indian/Alaska Native <input type="checkbox"/> 4. Asian <input type="checkbox"/> 5. Native Hawaiian/Other Pacific Islander <input type="checkbox"/> 6. Other Ethnicity: Hispanic/Latino Origin? <input type="checkbox"/> Yes <input type="checkbox"/> No										
5. Gender	<input type="checkbox"/> 1. Male <input type="checkbox"/> 2. Female										
6. County of Residence											

7. English Speaking ☐ Yes ☐ No Language

If no, language spoken: \_\_\_\_\_

8. Interpreter? ☐ Yes ☐ No Who? \_\_\_\_\_9. **Allergies:** (food, drugs, insects, environment)

10. DATE/AGE	/	/
11. REASON FOR THIS VISIT		
12. INFORMANT/RELATIONSHIP		
13. PARENTAL CONCERNS		
14. RECENT ILLNESSES/INJURIES (minor)		
15. OTHER HEALTHCARE PROVIDERS		
16. CURRENT MEDICATIONS		
17. SOCIAL: (Support Systems; Parent Employment; Interaction with Family Members; Family Violence)		
18. SCHOOL/CHILD CARE: (Grades; Performance; Absenteeism)		
19. BEHAVIOR/DEVELOPMENTAL CONCERNS		
20. DISCIPLINE: (Type; Frequency; Effectiveness)		
21. PLAY/ PHYSICAL ACTIVITY/ TV (Hours/Day)		
22. SLEEP: (Bedtime Problems; Nightmares; Back to Sleep)		
23. MAJOR EVENTS IN LIFE		
24. RISKS:		
a. Medications/Cleaning Supplies/Poisons		
b. Firearms		
c. Car and Bicycle Safety (Bicycle Helmet, Car Airbags, Car/Booster Seat, Car Seat Belt)		
d. Toys (Indoors/Outdoors); Playground & Farm Equipment		
e. Bathtub/Water Safety (Temperature; Life Jackets; etc)		
f. Exposure to Tobacco (House/Car)		
g. Smoke Detectors (working), CO Detectors		
h. TB Risk Assessment/Lead Screening Assessment		
25. REVIEW OF SYSTEMS:		
a. Skin		
b. Head		
c. Eyes		
d. Ears		
e. Nose		
f. Mouth (brushing, last dental exam/ dental varnish/sealant)		
g. Throat		
h. Respiratory		
i. Chest/Breast		
j. Heart		
k. Hematopoietic (bruising, bleeding)		
l. Gastrointestinal		
m. Genitourinary		
n. Musculoskeletal		
o. Neurological		
26. SIGNATURE		

Patient Name, #, or DOB  
or  
Attach Patient Label Here

## CHILD HEALTH FLOW SHEET

1. DATE/AGE						
2. Height/Length (Percentile)	W/H %	/ %	W/H %	/ %	W/H %	
3. Weight (Percentile)	BMI %	/ %	BMI %	/ %	BMI %	
4. Head Circumference/Percentile (Birth to 24 months)	/ %		/ %		/ %	
5. Hematocrit (hct) / Hemoglobin (hgb)						
6. Temp (as indicated)/Resp./ B/P (3+ years of age)						
7. Developmental Assess. (PSC; ASQ; PEDS; other)						
8. General Appearance						
9. Skin, Nodes						
10. Head						
Scalp/Fontanel						
11. Nose						
12. Eyes / Red Reflex/Pupils						
Muscle Balance	R	L	R	L		
Visual Acuity	R	L	R	L		
Glasses/ Color Vision						
13. Ear Canals	R	L	R	L		
Drums	R	L	R	L		
Hearing	R	L	R	L		
14. Mouth and Pharynx						
Teeth and Gums						
15. Neck						
16. Lungs/Chest						
17. Breast						
18. Heart (apical/femoral pulses)						
19. Abdomen						
20. Genitalia / Tanner Stage						
21. Extremities (Gait)						
Back and Spine (Posture)						
Hips						
22. Neurological						
23. Age Appropriate Anticipatory Guidance / Discussion						
a. Nutrition/Physical Activity						
b. Dental						
c. Safety						
d. Behavior/Discipline						
e. Development						
f. Hygiene						
g. Sex/Sexuality						
h. Emergency Care/Signs and Symptoms of Illness						
24. Lab Work This Visit						
25. Immunizations This Visit						
26. Treatments This Visit						
27. Comments:						
28. Referrals						
29. Next Appointment (date)						
30. SIGNATURE						

## **CHILD HEALTH FLOW SHEET (DHHS 2812)**

This flow sheet is designed to monitor normal growth and development of children through adolescence. It is used in addition to routine updates on the Child or Adolescent Basic History forms. The recommended schedule of visits is found in the Child Health Manual, as is a review of basic examination techniques.

Health problems which cannot be documented adequately with the code abbreviations, require a SOAP or narrative note on the Notes page. Record the letter "N" from the code in the appropriate box on the Child Health Flow Sheet, to reference information in the Notes.

- |                                    |  |
|------------------------------------|--|
| 1. -6. NAME, NUMBER, ETC           | In the blank space in the top left on the front, attach the computer generated label or emboss the information imprinted on the patient's identification card or manually record the patient's name (last name, first name, and middle initial), identification number, date of birth (MM-DD-YY), race and ethnicity, gender, and county of residence. |
| 7. ENGLISH SPEAKING                | Check "Yes" or "No" as appropriate. If "No", record language spoken.   |
| 8. INTERPRETER                     | Check "Yes" or "No" as appropriate. If "Yes", record who is providing interpretation.  |
| 9. ALLERGIES                       | List all of patient's allergies: food, drugs, insects, environment. Record in <u>red ink</u> if possible.  |
| 10. DATE/AGE                       | Enter the date of the examination and age of the child at the time of the examination at the top of each successive column. Do not anticipate visits by pre-dating columns.  |
| 11. REASON FOR THIS VISIT          | Record brief, specific statement about reason for visit. Use informant's words when possible (e.g., "shots", "ear re-check", or "6 months checkup") .  |
| 12. INFORMANT/RELATIONSHIP         | Record informant's relationship to the patient. As appropriate, note if informant is not able to provide thorough history.   |
| 13. PARENTAL CONCERNS              | Ask informant about any concerns which informant would like addressed at this visit. These often relate to the Reason For This Visit.  |
| 14. RECENT ILLNESSES/<br>INJURIES  | Ask about recent minor illnesses or injuries.  |
| 15. OTHER HEALTH CARE<br>PROVIDERS | Record names of any physician or other health care providers that the child sees or who are consulted on the child's care.   |

## DHHS 2812 (cont)

- |     |   |  |
|-----|---|--|
| 16. | CURRENT MEDICATIONS   | Note any medications or supplements the child receives, including prescription or OTC medications, vitamins, home remedies, etc.   |
| 17. | SOCIAL (Support Systems; Parent Employment; Interaction with Family Members; Family Violence) | Note any significant findings regarding the child's support systems.   |
| 18. | SCHOOL/CHILD CARE   | Record school/child care attendance, with grade level and grades, performance, absenteeism. Record concerns expressed.   |
| 19. | BEHAVIOR/<br>DEVELOPMENTAL<br>CONCERNS  | Record any concerns expressed by informant about behavior or development, including not meeting parental expectations in these areas. Record parent responses to behavioral problems. Note if developmental concerns/problems have been addressed and any treatments or interventions the child receives. Behavioral problems reported may include temper tantrums, nail biting, bed-wetting, thumb sucking, stealing, shyness, breath holding, biting playmates, lying, cheating, clinginess, hyperactivity, mood swings, changes in personality, and others. Developmental concerns may include late or unclear speech, late or awkward walking, among others. |
| 20. | DISCIPLINE  | Record method(s) of discipline/limit setting used by parents/caregivers. Record child's behavioral response to method(s) used and informant's assessment of method's effectiveness.  |
| 21. | PLAY/PHYSICAL ACTIVITY/<br>TELEVISION   | Ask informant about child's free time activities, amount of play time, toys available, amount of TV viewing/video games/other sedentary passive activities. Record hours per day child watches TV.   |
| 22. | SLEEP   | Record child's usual bedtime and awakening time, and number and length of naps as appropriate. Record any sleep problems reported by informant.  |
| 23. | MAJOR EVENTS IN LIFE  | Record any recent major events which have affected the child and family, such as births, deaths, divorces, moves, new pets, new schools, etc. Record any adverse reactions child demonstrated to these events.   |

## DHHS 2812 (cont)

24.	RISKS	Record any risks reported in categories below. Record any steps taken to protect child from these risks.
	Medications/Cleaning Supplies/Poisons	Ask about storage of these items, measures taken to keep them from child. Ask about child's exposure to or use of any illicit drug, alcohol, or tobacco.
	Firearms	Ask about presence and storage of firearms, ammunition, and other weapons.
	Car and Bicycle Safety	Ask about use of seat belts, car air bags, car/booster seat usage; Ask about use of bicycle safety helmets.
	Toys (Indoors and Outdoors), Farm and Playground Equipment	Record any hazardous toys or equipment in the child's home or environment.
	Bathtub and Water Safety	Ask about adult monitoring of child while around water or in the bathtub; bathtub temperature; life jacket use or swimming lessons.
	Exposure to Tobacco (House/Car)	Ask about any smokers among family members, frequent visitors in the home, or who care for the child. Note anyone who smokes inside the house or car or near the child. Ask if smoking materials are accessible to the child.
	Smoke Detectors (working) CO Detectors	Ask about presence and number of smoke and/or carbon monoxide detectors in home. Ask about frequency of battery checks.
	TB Risk Assessment/Lead Screening Assessment	Assess TB Risk criteria for child. Ask lead screening questionnaire or perform lead screening at required age intervals.
25.	REVIEW OF SYSTEMS	Review each major body system for significant positive or negative findings. For "sick" or "re-check" visits, address those items most helpful in defining the child's current problem(s). The prompts given below are guides, but not all inclusive.
	Skin	Infections, rashes, bruises, birthmarks, lumps
	Head	Injury, headache, hair loss, scalp infections
	Eyes	Irritation, rubbing, crossed eyes, vision concerns, use of glasses or contacts
	Ears	Pain, pulling, infection, concerns about hearing or speech

## DHHS 2812 (cont)

### 25. REVIEW OF SYSTEMS (cont)

Nose	Discharge, bleeding, rubbing, congestion, noisy breathing
Mouth	Pain, sores, gums, teeth, dental care, tooth brushing, last dental exam/dental varnish/sealants, mouth breathing
Throat	Throat or neck pain, swelling, stiffness, history of Tonsillitis
Respiratory	Wheezing, asthma, cough, difficult breathing, pneumonia, shortness of breath, chest pain
Chest/Breast	Pain, pubertal development
Heart	History of or current murmur tiring easily, fainting upon exertion, cyanosis, chest pain, feelings of racing pulse
Hematopoietic	Anemia, tendencies to bruise or bleed easily
Gastrointestinal	Weight or appetite changes, special diets, pain, nausea, vomiting, diarrhea, constipation, bleeding, pica, "worms", toilet training
Genitourinary	Pain, frequency, infections, toilet training
Musculoskeletal	Breaks, pain, strains, sprains, swelling, tenderness, stiffness, limitations
Neurological	Seizures, tremors, fainting, weakness, clumsiness, fatigue

26. SIGNATURE Record the full legal signature of health professional responsible for this information.

## **CHILD HEALTH FLOW SHEET- BACK SIDE (DHHS 2812)**

- |         |  |   |
|---------|--|---|
| 1.      | DATE/AGE   | Enter the date of the examination and the age of the child at the time of the examination at the top of each successive column. Do not anticipate visits by pre-dating columns.   |
| 2.      | HEIGHT/LENGTH<br>(Percentile)                          | Record the measurement in centimeters or inches.<br>Record the height/length for age percentile.  |
| 3.      | WEIGHT (Percentile)                                    | Record measurement in kilograms or pounds.<br>Record the weight for age percentile.<br><br>Record the weight for height/length percentile in the box marked W/H %<br><br>Record the Body Mass Index (BMI) percentile in the box marked BMI %  |
| 4.      | HEAD CIRCUMFERENCE<br>(Percentile)                     | Record measurement in centimeters or inches for children birth to 24 months of age, and those with personal or family histories of macrocephaly or microcephaly. Record the head circumference percentile.                                    |
| 5.      | HCT/HGB  | Record laboratory values obtained this visit or within the past 90 days. If value is not from this visit, note date of laboratory value next to value.  |
| 6.      | TEMP/RESP/B.P.   | Record temperature (if indicated), respirations per minute, and blood pressure (for children 3 years of age and older).   |
| 7.      | DEVELOPMENTAL<br>SCREENING (PSC,<br>ASQ, PEDS, other)  | Record status as well as measure used to evaluate developmental status.   |
| 8. -22. | PHYSICAL EXAMINATION                                   | Record findings of standard physical examination procedures. See Child Health Manual for detailed instruction on performing and record results of physical examinations.<br><br>For Visual Acuity and Hearing Screen, use quantifiable terms. |
| 23.     | AGE-APPROPRIATE<br>ANTICIPATORY<br>GUIDANCE/DISCUSSION | Record routine health guidance/discussion provided as it relates to the age of child at this visit.   |
| 24.     | LAB WORK THIS VISIT                                    | Record lab work requested/ordered for this visit and results if applicable.   |

## **DHHS 2812- Back Side (cont)**

- |     |                               |   |
|-----|-------------------------------|---|
| 25. | IMMUNIZATION(S)<br>THIS VISIT | Record immunization(s) ordered/received at visit.   |
| 26. | TREATMENTS THIS VISIT         | Record any treatments (if applicable) ordered this visit.   |
| 27. | COMMENTS                      | Record additional comments (if applicable).   |
| 28. | REFERRALS                     | Record type or name, referrals to other health care providers, or other WCH or local agency programs.   |
| 29. | NEXT APPOINTMENT              | Record the date given to the patient and family for the next scheduled visit. Note if next visit is for re-check of findings/problems found this visit. See Child Health Manual for periodicity schedule. If unable to schedule a specific screening date, note month and year that patient is due for next routine examination. If child has no additional appointments, note age when next routine screening is needed. |
| 30. | SIGNATURE                     | Record full legal signature of health professional responsible for the physical examination.  |